

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 002656	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/12/2016
NAME OF PROVIDER OR SUPPLIER BROOKDALE GRANGER		STREET ADDRESS, CITY, STATE, ZIP CODE 430 CLEVELAND RD GRANGER, IN 46530		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00196876.</p> <p>Complaint IN00196876- Unsubstantiated due to lack of evidence.</p> <p>Survey dates: April 11, and 12, 2016.</p> <p>Facility number: 002656 Provider number: 002656 AIM number: N/A</p> <p>Residential census: 37</p> <p>Sample: 3</p> <p>Brookdale Granger was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00196876.</p> <p>QR was completed by 99993 on 04/13/16.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE